

Availability of Primary Health Care

Summary

Primary care practitioners are usually a patient's first point of contact for medical health services. These practitioners give continuous coordinated care for patients. An estimated 673 primary care practitioners are needed to eliminate current shortages statewide.

Recruitment and retention activities are the primary means to eliminate shortages. Other programs that produce results are education programs targeting clinical practice in rural areas or community/migrant or American Indian health centers, and loan repayment/scholarship programs.

The state works collaboratively with communities to assess local shortages and develop plans for local recruitment and retention of primary care health practitioners.

Time Trends

According to the U.S. Department of Health and Human Services there was improvement in the ratios of primary providers to population between 1969 and 1994. In 1969 there was one family practice/general practitioner for every 3,000 people. In 1994, there was one practitioner for every 2,560 people.

Similarly, the national ratio of combined family practice/general practitioners, pediatricians, and general internists improved from 1/1,704 in 1969 to 1/1,230 in 1994.

Year 2000 Goal

While activities to assess and eliminate practitioner shortages are implemented continuously, there is no established Year 2000 goal. The obvious long-term goal is elimination of health practitioner shortages in all areas of the state.

Until this is met, the Department of Health has adopted, as a goal, the national standard for primary care practitioners and general hospital

Definition: Primary care practitioners are: medical and osteopathic doctors (MD & DO) who specialize in family/general practice, obstetrics/gynecology, general internal medicine, or pediatrics; naturopathic physicians; physician assistants; and advanced registered nurse practitioners in family/general, geriatric, or pediatric practice, and women's health care. Availability is determined by using a ratio of provider to population after adjusting the population and practitioner data and adding variables of poverty, prenatal care and aged population (see technical note).

services. Practitioners and facilities should be available within twenty miles or thirty minutes travel time for at least 90% of the population. At the present time the number of people outside these two parameters is estimated at 100,000 or 2% of the population, so this goal is being met.¹

Geographic Variation

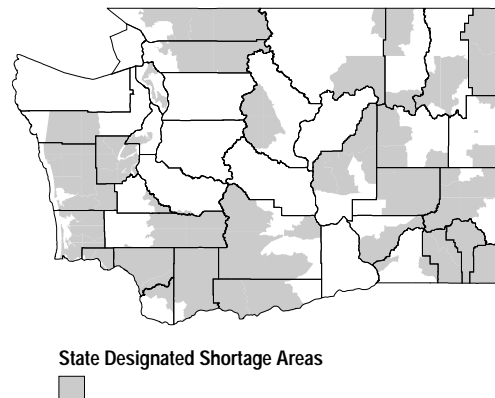
In the Health Personnel Resource Plan, data on regulated health care practitioners are presented by Health Service Areas (HSA). An HSA is composed of a group of zip codes clustered around a health entity such as a hospital, medical center, clinic, or hospital district.

The map on this page shows HSAs that were classified as state shortage areas for primary care providers in 1995.² Fifty-eight of the HSAs (51%) have a shortage.

All HSAs with shortages are rural, with the exception of a very small urban area in the city of Spokane.

According to the Health Personnel Resource Plan (HPRP), 673 primary care practitioners would be needed to eliminate all shortages. Each HSA

State Designated Shortage Areas
For General Care Providers



can decide which type of primary care practitioner (see definitions) will best fit its needs. The technical notes at the end of this discussion address HPRP data limitations.

Other Measures of Impact and Burden

The total number of credentialed practitioners is more than enough to give primary health care to each person in the state, but maldistribution results in localized shortages. Some of this is due to primary care practitioners working in faculty or administrative positions; some is due to clustering of practitioners in metropolitan areas.

If general health practitioners are not available to provide care or to accept patients for treatment, there is impact on:

Other primary care practitioners who must treat more patients and work longer hours.

Hospital emergency rooms and local emergency systems where emergency medical personnel (physicians, physician assistants, nurse practitioners) act as the primary care provider.

Other Practitioners who may be the first point of contact (for example, chiropractors, mental health practitioners, ophthalmologists/optometrists, or podiatrists).

The higher educational system which must modify admissions, programs, and curricula to meet needs for new or expanding professions and reeducate personnel to fill shortage professions.

Private payers and governmental programs which purchase health care and attempt to assure access to services.

The rural health infrastructure if personnel are lacking to staff the rural system. The loss of even one rural practitioner will impact health care in the community.

Prenatal and postpartum care for uncomplicated births is usually provided by primary care providers. The percentage of family practice physicians delivering babies in Washington decreased from 61% in 1985 to 46% in 1989.³ This could have been caused by a 1985 increase in malpractice insurance premiums for obstetrics. The Maternity Access Act of 1989 (First Steps Program) increased Medicaid reimbursement to obstetric providers and is reversing the trend.

Education of practitioners can require several months to 12 years or more. Curriculum revisions can also take several years to implement.

Risk and Protective Factors/High-Risk Groups

The HPRP study results found that a simple ratio of practitioners to population is not adequate to determine where, according to community leaders, shortages of primary care practitioners were located. Therefore the analysis was modified with variables related to three high-risk groups: those in poverty, the elderly, and women in need of prenatal care. Standard scores for the variables were added to the ratio analysis to determine the state-designated shortage areas for primary care practitioners. This analysis resulted in the shortage of 673 practitioners as reported above.

Intervention Points, Strategies and Effectiveness

Community Assessment Activities. Community assessment of the need for practitioners is the first step in addressing shortages. Assessment activities include collaboration among communities, state, and private agencies. An accurate assessment can determine the type of primary care practitioner needed. Positive recruitment actions and information to reduce retention problems are one result.

Federal/State Programs. The use of state and federal grants has helped Washington develop a network of 59 community/migrant health clinics, 26 Indian Health Service/tribally operated health programs, and two urban Indian health programs.⁴

Loan repayment programs to health providers with a pay-back obligation are an incentive to primary care practitioners to work in underserved areas and, in Washington, there is a high rate of retention. Since 1990 the loan repayment program has directed 42 practitioners to targeted areas of need. Since 1993, all of the practitioners who completed their contracts stayed in their shortage areas.⁵

In addition, the state currently has about 150 scholarship recipients working in underserved areas.

National Health Service Corps. In 1995 the following practitioners from the National Health Service Corps were located in underserved areas:⁶

- 34 family practice physicians
- 11 nurse practitioners/physician assistants
- 1 psychiatrist
- 13 dentists

Educational Institutions with health professions programs develop institutional plans

designed to address recommended strategies of the current Health Personnel Resource Plan.

Primary care physician and dental programs need financial help with rural clinical training of students. Clinical training could shift from hospital-based to a combination of community and hospital-based so that future practitioners can learn about the special demands of rural health.

Cross-credentialing of certain skill or procedure sets between some professions can decrease the need for more practitioners to be educated in the health professions. For example, a nurse who is also credentialed as a lab assistant can work in both departments (lab and clinical nursing) resulting in a saving to the hospital. One community college in the state has successfully integrated nursing, lab assistant, and respiratory therapy assistant programs to train health care technicians who enable rural hospitals and home care employers to provide more comprehensive care to clients.

Recruitment and retention that is successful aids in maintaining the fragile rural health infrastructures. The following activities could be reliable aids in recruitment and retention:

- Establishment of community-based rural health system networks.
- Financial incentives such as tax credits, larger reimbursement policies and yearly bonuses.
- Continuing education programs and more rural substitute practitioners (locum tenes program).
- State clearinghouse for recruitment.
- Technical assistance to communities including immigration issues.
- In-state retention of more graduates from health care education and training programs

Other Practitioners providing care in underserved urban areas are often the first point of contact with the public. Taking advantage of nearby services in an urban area is an obvious strategy; but two barriers are transportation and the issue of payment. These practitioners often do not accept the Medicare/Medicaid reimbursement or they are not eligible to receive reimbursement.

Data Sources

1994 Masterfile of Physicians, American Medical Association
1995-97 Washington State Health Personnel Resource Plan
Health Maintenance Organization Industry Profile (1993 Edition)
Health Personnel Factbook of United States (USDHHS 1993).
Health Professions Licensing Data Base, Health Professions Quality Assurance Division, Washington State Department of Health

National Health Information Survey, US Department of Health and Human Services
Strategic Mapping Incorporated
Washington State Birth Records, Health Information Division, Washington State Department of Health
United States Bureau of the Census
Washington State Office of Management and Budget
United States Department of Health and Human Services

For More Information

For information on the Health Personnel Resource Plan contact the Office of Health Services Development (360)586-1334

Technical Notes

In the Health Personnel Resource Plan numbers of all credentialed personnel other than generalists, dentists, and dental hygienists were taken from the professional licensing system. The practitioners count was adjusted to count only those with an active license living within state boundaries and 63 years of age or under. It is a personal choice to keep an active license which means the count may include those who are retired, work part time or do not work; therefore the numbers may be inflated.

The population of each area was adjusted for gender and age to account for differences in use of health services.

The Health Services Act of 1993 legislated access to basic health services for all citizens. The 1995-97 plan was based on that assumption and used a national Health Maintenance Organization ratio of 1 practitioner to 1200 population (1:1200) to determine shortages. Three variables were introduced: percent of population aged 65 years and older; percent of population at 200% below the poverty level; and scores for inadequate prenatal care (Kotelchuck percentage). Standardized scores were calculated for each variable in each health service area and the three scores were averaged. To be named a shortage area, the average standard score had to be 100 or more and the area had to show a shortage using the 1:1200 ratio.

Numbers of physicians needed for the Federal Health Professional Shortage Areas do not agree with numbers needed from state designated shortage areas; however, federal data are not as limiting as the rules to determine state shortages, and the federal areas are by county, population or larger geographic areas, not the Health Service Areas used by the state.

Endnotes:

¹ Office of Rural Health, Department of Health.

² 1995-95 Health Personnel Resource Plan, Department of Health.

³ Rural Obstetrical Access in Washington State: Have We Attained Equilibrium? Rosenblatt et al. Rural Health Working Paper Series #6, WAMI Rural Health Research Center, University of Washington.

⁴ Office of Rural Health, Department of Health.

⁵ Washington State Higher Education Coordinating Board.

⁶ Office of Rural Health, Department of Health.